CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE

BOARD OF DENTISTRY AND DENTAL HYGIENE

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@state.de.us

APPLICATION FOR DENTIST ACADEMIC LICENSURE
INSTRUCTION SHEET

When to File

File this application for Delaware Dentist Academic licensure if you are a full-time director, chairperson, or attending faculty member of a hospital-based dental, oral and maxillofacial surgery or other dental specialty residency program. The program must be

- based in Delaware, and
- accredited by the Commission on Dental Accreditation of the American Dental Association (CODA) for the purposes of teaching, has received initial CODA accreditation or is in the process of establishing CODA accreditation

The academic license allows you to practice dentistry or oral and maxillofacial surgery *only* in the institution designated on the license and only on patients in an academic setting for teaching purposes.

Requirements for All Applications

☐ Submit a completed, signed and notarized *Application for Dentist Academic Licensure*.

☐ Enclose the non-refundable processing fee by check or money order made payable to "State of Delaware."

☐ Arrange for the Board office to receive an official transcript from Board-recognized undergraduate college or university, sent directly from the school to the Board office. The transcript must show that you completed at least two years of undergraduate study in an accredited college or university.

☐ Arrange for the Board office to receive an official transcript from your dental college or university, sent *directly* from the school to the Board office. The transcript must show your degree and date of graduation.
- The dental college/university must be CODA-accredited.

☐ Arrange for the Board office to receive ***one*** of the following:
- Tax form W-2s or other proof that you have practiced actively for three years in another jurisdiction (state, U.S. territory or District of Columbia)
- Proof (such as a letter from the sponsoring institution) that you have one year of experience as a dental intern in a CODA-accredited general practice residency sent directly from the sponsoring institution to the Board office
- Proof (such as a letter from the sponsoring institution) that you have completed four or more years in a CODA-approved specialty residency, sent *directly* from the sponsoring institution to the Board office

☐ Arrange for the Board office to receive license verification letters from *each* jurisdiction (state, U.S. territory or District of Columbia) where you are now, or have ever been, licensed, sent *directly* from the jurisdiction to the Board office.

☐ If you have ever been licensed in another jurisdiction, request a self-query from the National Practitioner Data Bank. When you receive the report, send the original to the Board office.

☐ Complete the *Criminal History Record Check Authorization* form to request State of Delaware and Federal Bureau of Investigation criminal background checks. Follow the instructions on the authorization form to arrange to be fingerprinted.

☐ If you have never been issued a U.S. Social Security Number (SSN), submit a *Request for Exemption from Social Security Number Requirement*.
The Privacy Act of 1974, Section 7, requires the following information to be given to all applicants: Applicants for any Delaware professional or occupational license, permit, registration or certificate (other than Gaming permits) are required to provide a U.S. SSN (29 Del. C. §8735(m)). The Division of Professional Regulation uses the SSN primarily to verify identity and safeguard personal information. It may also be used to enforce child support obligation (13 Del. C. §2216) and for other lawful purposes.

☐ Enclose a copy of your current cardiopulmonary resuscitation (CPR) certification card.

☐ Arrange for the Board office to receive verification that you are "Board Certified" or "Board Eligible" in general dentistry or in a dental specialty.
- If you are in the process of acquiring "Board Certification" or "Board Eligible" status, you must obtain full "Board Certification" or "Board Eligible" status in general dentistry or in a dentistry specialty within five years. If you do not provide the proof, your license will not be renewed.

☐ Submit proof that you have been appointed as a full-time director, chairperson, or an attending faculty member of a hospital-based dental, oral and maxillofacial surgery or other dental specialty residency program.
- The facility must be based in Delaware.

☐ Arrange for the Board office to receive verification of the hospital facility's CODA accreditation status.
- If the hospital facility has received initial CODA accreditation or is in the process of establishing CODA accreditation, the hospital facility must attain full CODA accreditation status within two years of your licensure. Submit proof of the full CODA accreditation when it is attained.

Pursuing Full Dentist Licensure

You may renew your Academic Dentist license on the same two-year cycle as other Delaware dentistry licenses. (See License Renewal) However, if you wish to qualify for a full Dentist license, you must pass the Delaware Practical Board Examination in dentistry and the Delaware Jurisprudence Examination *regardless of your years of practice*. If you wish to pursue full Dentist licensure, these are the requirements:

☐ Submit your completed, signed and notarized Delaware Jurisprudence Examination for Dentist Candidates.

☐ Arrange for the Board office to receive your National Board Examination score report, sent *directly* from the Joint Commission on National Dental Examinations to the Board office. See Score Report Request.

☐ Contact the Board office to arrange to sit for the Delaware Practical Board Examination.
- ☐ Submit payment for the non-refundable examination fee by check or money order made payable to "State of Delaware." Please indicate with your examination fee which exam you wish to sit for. If you fail to sit for the examination in the month you select on the application, ***you will forfeit this fee***. You cannot transfer it to the next examination date.
- ☐ If you choose to submit your non-refundable examination fee after the deadline for the exam you want to take (May 1 for the June exam or December 1 for the January exam), enclose the non-refundable Late Exam fee. This fee is in addition to the processing fee and examination fee.
  - ***You will be admitted to the exam only if a seat is still available.***
  - If no seat is available, ***you will forfeit both the examination fee and late fee that you paid.*** To register for the next exam date you must pay the examination fee again. You cannot transfer it to a later examination date.

Information about Required Examinations

The Delaware Practical Board Examination is offered twice a year, at the beginning of January and June. The deadlines for applications to sit for the exams are December 1 for the January exam and May 1 for the June exam. The exam is limited to 18 candidates on each date. It is important to submit your application before the deadline for the exam you want to take.

The Delaware Jurisprudence Examination for Dentists is an "open-book" test with 30 multiple-choice questions. It is based on the Delaware Code and the Board's Rules and Regulations.

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APPLICATION FOR DENTIST ACADEMIC LICENSURE

IDENTIFYING AND CONTACT INFORMATION

1. Name: _____ _____ _____ _____
   Last/Family Name | First | Middle | Maiden

2. Other Name(s) Used: ☐ None _____ _____ _____

3. Have you ever sought or been granted a dental license under another name? Yes ☐ No ☐ If yes, enter name and state where you used the name: _____

4. Date of Birth (month/day/year): _____ Gender: Male ☐ Female ☐

5. Have you been issued a U.S. Social Security Number? Yes ☐ No ☐ **If yes, enter your SSN:**_____
   If no, you must file a *Request for Exemption from Social Security Number Requirement*.

6. *Mailing* Address: _____

   _____ _____ _____
   City | State | Zip

7. Phone: _____ _____ Email: _____ ☐ None
   Daytime | Home

INFORMATION ABOUT ACADEMIC ROLE

8. Have you been appointed as the full-time director, chairperson, or an attending faculty member of a hospital-based dental, oral and maxillofacial surgery or other dental specialty residency program. Yes ☐ No ☐
   - If yes, enter your position: _____ **Submit documentation of your appointment.**
   - If no, STOP. To qualify for an Academic Dentist license, you must hold an appointment to a position named.

9. Have you obtained "Board Certification" or "Board Eligible" status in general dentistry or in a dentistry specialty? Yes ☐ No ☐
   - **If yes, submit documentation of your status. Skip to Question 11.**
   - **If no, you must acquire and submit proof of "Board Certification" or "Board Eligible" status within five years. Continue to Question 10.**

10. Do you understand that you must provide proof that you are "Board Certified" or are "Board Eligible" in general dentistry or a dentistry specialty within five years of licensure and that, if you do not provide the proof, your license will not be renewed? Yes ☐ No ☐

11. Enter the following information about the hospital facility where you will be working:

    Facility: _____

    Address: _____

    _____ DE _____
    City | State | Zip

    Contact Name: _____ Contact Phone: _____

12. Do you understand that a Dentist Academic license allows you to practice dentistry or oral and maxillofacial surgery only in the facility named above and only on patients in the named facility for teaching purposes? Yes ☐ No ☐

13. Has the facility named above received full CODA accreditation for teaching purposes? Yes ☐ No ☐
    - **If yes, submit documentation on the facility's status. Skip to the EDUCATION AND RESIDENCY section.**
    - **If no, the facility must attain full accreditation within two years of your licensure. Continue to the next question.**

14. Do you understand that the facility must attain full CODA accreditation within two years of your licensure and that, if you do not submit proof when it is attained, your license may be renewed only after the Board reviews the program status? Yes ☐ No ☐

EDUCATION AND RESIDENCY

15. Enter the following information about your pre-professional education:

    University/College: _____ Major: _____

    City: _____ State: _____ Degree: _____

    Dates Attended: From: _____ (month/day/year) To: _____ (month/day/year) Graduation Date: _____ (month/day/year)

    Arrange for the Board office to receive an official transcript, sent *directly* from the college/university to the Board office.

16. Enter the following information about your Dental education:

    Dental School Name: _____

    City: _____ State: _____ Degree: _____

    Dates Attended: From: _____ (month/day/year) To: _____ (month/day/year) Graduation Date: _____ (month/day/year)

    Arrange for the Board office to receive an official transcript, sent *directly* from your dental school to the Board office.

17. Have you completed a CODA-approved residency program? Yes ☐ No ☐ If no, skip to Question 18. If yes, complete the following information about your residency program, then skip to the **LICENSURE HISTORY** section.

    Name of Sponsoring Institution: _____

    Mailing Address: _____

    _____ (City) _____ (State) _____ (Zip)

    Start Date (month/year): _____ End Date (month/year): _____

    Type of Residency: ☐ General Practice

    Arrange for the Board office to receive proof (such as a letter from the sponsoring institution) that you have one year of experience as a dental intern in this residency sent directly from the sponsoring institution to the Board office.

    ☐ Specialty – Identify specialty: _____

    Arrange for the Board office to receive proof (such as a letter from the sponsoring institution) that you have completed the residency sent directly from the sponsoring institution to the Board office.

18. Do you have three years of active dental practice? Yes ☐ No ☐ If yes, complete the following showing three years' of practice:

EMPLOYER NAME	CITY	STATE	DATES (month/day/year)	
			From	To

Enclose Tax form W-2s documenting the periods listed above.

LICENSURE HISTORY

19. Have you ever been denied a license? Yes ☐ No ☐ If yes, enter: Year Denied: _____ State: _____
    Explain why the license was denied: _____
    _____

20. Are you (*or have you ever been*) licensed in any other jurisdiction? Yes ☐ No ☐ If yes, enter the following information about *each* license:

JURISDICTION	LICENSE NUMBER	ISSUE DATE	EXPIRATION DATE	STATUS (e.g.,active)

Arrange for *each* jurisdiction listed to send a verification of licensure *directly* to the Board office. Also, request a self-query from the National Practitioner Data Bank. When you receive the report, send the original to the Board office.

DISCLOSURES

21. Have you engaged in the illegal use of controlled dangerous substances within that past two years? Yes ☐ No ☐ If yes, continue to Question 22. If no, skip to Question 23.

22. Are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not illegally using controlled substances? Yes ☐ No ☐ **If yes, explain fully:**
    _____
    _____

23. Have you ever been denied a DEA (Narcotic) registration number? Yes ☐ No ☐ Current DEA #_____
    If yes, submit a signed statement explaining fully.

24. Has your professional license ever been subjected to disciplinary action (including but not limited to consent agreements, fines, probation, suspension or revocation)? Yes ☐ No ☐ **If yes, submit a signed statement explaining fully. Include an official Board order or other documents.**

25. Has any malpractice action been brought against you in the past five years? Yes ☐ No ☐ **If yes, enclose a list on a separate sheet of paper. Include dates, disposition and amount of awards or settlements, if any.**

26. Are any disciplinary or ethical complaints currently pending against you? Yes ☐ No ☐ **If yes, submit a signed statement fully explaining. Include copies of all official documents or Board orders.**

27. Are you physically or mentally incapable of engaging in the practice of dentistry according to generally accepted standards? Yes ☐ No ☐ **If yes, continue with Question 28. If no, skip to the DUTY TO REPORT section.**

28. Do you agree to submit to an examination to determine such capability as the Board may deem necessary?
    Yes ☐ No ☐

Complete the *Criminal History Record Check Authorization* form to request State of Delaware and Federal Bureau of Investigation criminal background checks. Follow the instructions on the authorization form to arrange to be fingerprinted.

DUTY TO REPORT

29. To obtain a license in Delaware, you must certify that you understand that you have a **mandatory** obligation to self report any of the following within 30 days:

    - Any arrest or the bringing of an indictment or information charging you with a crime substantially related to the practice of dentistry and dental hygiene as defined in Section 11.0 of the Board's Rules and Regulations.
    - Any conviction, including any verdict of guilty or plea of guilty or no contest, of any crime substantially related to the practice of dentistry and dental hygiene as defined in the Section 11.0 of the Board's Rules and Regulations.

    I certify that I have read and understand all provisions in the Delaware Dental Practice Act, including 24 *Del. C.* §1131 and the Rules and Regulations listed above, and that I understand my *duty to self report*. Yes ☐ No ☐

30. To obtain a license in Delaware, you must certify that you understand that you have a ***mandatory*** obligation to make an immediate oral report to the to the Department of Services for Children, Youth and Their Families if you know of, or you suspect, child abuse or neglect under Chapter 9 of Title 16 and to follow up with any requested written reports.

    I certify that I have read and understand 16 *Del. C.* §903 and that I understand my *duty to report*. Yes ☐ No ☐

31. You have a ***mandatory*** duty to file a written report with the Division of Professional Regulation within 30 days if you reasonably believe that any other dental or dental hygiene practitioner ***or*** any other healthcare practitioner, including any person licensed to practice medicine in Delaware:
    - has engaged in or is engaging in conduct that would constitute grounds for disciplinary action
    - may be unable to practice with reasonable skill and safety to the public due to mental illness or mental incompetence, physical illness (including deterioration through the aging process or loss of motor skill), or excessive abuse of drugs (including alcohol)
    - is excessively using or abusing drugs including alcohol.

    I certify that I have read and understand the provisions of 24 *Del. C.* §1131A and that I understand my *duty to report*. Yes ☐ No ☐

To ensure consideration of your license application at the next Board meeting, the Board office must receive all of these items no later than 4:30 PM ten full working days before the Board's meeting date:

- **Completed, signed and notarized application form**
- **Fee payment**
- **All required supporting documentation.**

Applications that are not complete within 12 months of filing may be considered abandoned and discarded. When your application is complete, please allow 4-6 weeks to receive your license.

AFFIDAVIT

I hereby apply to be considered for licensing as a Dentist by the Board of Dentistry and Dental Hygiene under the standards, qualifications and procedures established under Title 24, Chapter 11, of the *Delaware Code*. I have read the State statute governing dentists in Delaware. I have also received and read the Board's Rules and Regulations regarding the practice of Dentistry in Delaware. I understand that the Board may require evidence additional to the material herein, including a written examination, and transcripts of academic training.

I hereby swear or affirm that the information contained in this application is correct and I understand that any intentionally fraudulent information will be reported to the Attorney General.

Applicant Signature: _____ Date: _____

County of_____ State of _____

Sworn or affirmed before me a Notary Public this_____ day of _____, 2_____.

Notary Signature: _____

SEAL

My commission expires on_____

APPLICATIONS THAT ARE UNSIGNED, NOT NOTARIZED, INCOMPLETE OR SUBMITTED WITHOUT THE REQUIRED FEE WILL BE REJECTED.

Instructions for Requesting a Criminal Background Check

Both State of Delaware and Federal Bureau of Investigation criminal background checks are required.

Applicant Notification

Your fingerprints will be used to check the criminal history records of the Federal Bureau of Investigation (FBI). You have the opportunity to challenge the accuracy of the information contained in the FBI identification record. See Title 28, CFR 16.34 for the procedure to obtain a change, correction or update in the FBI record.

Locations

Kent County – Primary Facility
State Bureau of Identification
Blue Hen Mall & Corporate Center
655 S. Bay Rd. Suite 1B
Dover, DE 19901
Walk-ins accepted: Mon 8:30 am – 6:30 pm, Tue - Fri 8:30 am – 3:30 pm
Customer Service: (302) 739-2134

New Castle County - Satellite Facility
State Police Troop Two
100 LaGrange Ave
Newark, DE 19702
(between Rts. 72 and 896 on Rt. 40)
By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Sussex County – Satellite Facility
Thurman Adams State Service Center
546 S. Bedford Street, Rm. 202
Georgetown DE 19947
(across from DelDOT & Troop 4)
By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Applicants in Delaware

1. If you are using the New Castle County or Sussex County locations, call **(800) 464-HELP (4357)** to schedule an appointment. No appointments are needed at the Kent County location.

2. Take the completed *Authorization for Release of Information* form to one of the offices listed above with the fee of $65.00, to cover both the State of Delaware and Federal Bureau of Investigation criminal checks. Money orders and credit cards other than American Express are accepted at all locations. New Castle and Kent Counties accept cash; Sussex County does not accept cash. ***Personal checks are not accepted in any county.*** As fees are subject to change, contact the agency where you plan to submit your forms for current fees.

Applicants Not in Delaware (including Out-of-State or Outside the United States)

1. Your local police agency can fingerprint you. All types of fingerprint cards are accepted. Or, you may print a FD-258 fingerprint form available on the FBI website at www.fbi.gov – click *Services*, then *Identity History Summary Checks*, then scroll down to Option 1, Step 2, and click the link for *standard fingerprint form (FD-258)*. You may print the form on regular paper.

2. Your *Authorization for Release of Information* form and the fingerprint card must be complete. If identifying information is missing (such as name, date of birth, race, gender, etc.), your form will be returned.

3. ***Mail*** the *Authorization* form, fingerprint card, and *certified* check or money order ***(personal checks are not accepted)*** for $65.00 made payable to "Delaware State Police" to:

Delaware State Police
State Bureau of Identification (SBI)
PO Box 430
Dover, DE 19903-0430

DO NOT SEND THIS FORM OR FEE TO YOUR PROFESSION'S BOARD OFFICE.

DO NOT SEND THIS FORM OR FEE TO THE DIVISION OF PROFESSIONAL REGULATION.

⇨ALLOW FOUR WEEKS FOR RECEIPT OF RESULTS.

Revised 6/2017

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AUTHORIZATION FOR RELEASE OF INFORMATION

CRIMINAL HISTORY RECORD CHECK FOR PROFESSIONAL LICENSURE APPLICANTS

Please print or type all information in black ink.

Check the type of license for which you are applying:

- ☐ Adult Entertainment
- ☐ Charitable Gaming Vendor
- ☐ Chiropractic
- ☐ Dental
- ☐ Funeral
- ☐ Massage
- ☐ Medical (Physicians, Physician Assistants, Respiratory Care Practitioners, Eastern Medicine Practitioners, Acupuncture Practitioners, Genetic Counselors, Polysomnographers, Midwifery Practitioners (CM, CPM))
- ☐ Mental Health (LPCMH, LCDP, LMFT, LAPCMH, LAMFT)
- ☐ Nursing (RN, LPN, APRN)
- ☐ Nursing Home Administrator
- ☐ Occupational Therapy
- ☐ Optometry
- ☐ Pharmacy (includes key personnel of facilities licensed by Board of Pharmacy)
- ☐ Physical Therapy/Athletic Trainer
- ☐ Podiatry
- ☐ Psychology
- ☐ Real Estate Appraiser (includes Appraisal Management Company)
- ☐ Speech/Hearing
- ☐ Social Work
- ☐ Texas Hold'em Individual

Print your current full name:

_____ _____ _____ _____
Last Name First Name Middle Initial Suffix (e.g., Jr., Sr.)

Enter all other names you have used in the past (including, but not limited to, maiden name, former married names, alternative spellings):

1. _____
2. _____
3. _____
4. _____

As an applicant, I authorize release of any and all information that you have concerning my **CRIMINAL HISTORY RECORD INFORMATION**. I hereby release you, your organization, the State of Delaware and others from any liability or damage which may result from furnishing this information:

SIGNATURE OF PERSON PRINTED: _____ **Date**: _____

Phone: Home _____ Work _____

Mail the results of my criminal history request to:

Division of Professional Regulation
861 Silver Lake Boulevard, Suite 203
Dover DE 19904
SLC D420A

USE OF CRIMINAL HISTORY RECORD INFORMATION IS RESTRICTED BY LAW AND SHALL BE LIMITED TO THE PURPOSE FOR WHICH IT WAS GIVEN. MISUSE CONSTITUTES A CRIMINAL VIOLATION.

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